



Illinois Department of Public Aid

no. : Ch100-03-1

ILLINOIS MEDICAL ASSISTANCE PROGRAM PROVIDER BULLETIN

06/27/03

TO: Participating Medical Assistance Programs Providers

RE: Handbook for Providers of Medical Services, Chapter 100-General Policy and Procedures June 2003 Update

The Department has made several changes to the Handbook for Providers of Medical Services, Chapter 100-General Policy and Procedures. This handbook update includes:

- Language regarding the Department's programs on Health Benefits for Persons with Breast and Cervical Cancer and Health Benefits for Workers with Disabilities.
- Language regarding participant copayments
- Revised KidCare Card
- Error codes - adding 4 and deleting 1
- Updates in terminology to reflect current usage.

The replacement pages are also available on the Department's website at:

<http://www.state.il.us/dpa/html/all_medical_assistance_provide.htm>. If you do not have access to the Internet, or need a paper copy, printed copies are available upon written request. You need to specify a physical street address to ensure delivery. Submit your written request or fax to:

Illinois Department of Public Aid
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114
Fax Number: (217) 557-8800
E-mail address is PPU@mail.idpa.state.il.us

The revised pages are dated June 2003. The affected items are designated by "=" signs to the left. This Provider Bulletin lists the pages to be removed and replaced.

If you have any questions regarding this bulletin, please contact the Bureau of Comprehensive Health Services at (217) 782-5565.

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CHAPTER 100

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CHAPTER 100

GENERAL POLICY AND PROCEDURES

100 DPA MEDICAL PROGRAMS - BASIC PROVISIONS, AUTHORITY AND OBJECTIVE

For consideration for payment by the Department under any of its authorized programs, covered services must be provided to an eligible participant by a medical provider enrolled for participation in the Illinois Medical Assistance Program. Services provided must be in full compliance with applicable federal and state laws, Department Administrative Rules (89 Ill.Adm.Code Chapter 101), the general provisions contained in Chapter 100, General Policy and Procedures, and the policy and procedures contained in the Chapter 200 series Handbook that applies to the specific type of service or type of provider.

The objective of the Department's Medical Programs is to enable eligible participants to obtain necessary medical care. "Necessary medical care" is that which is generally recognized as standard medical care required because of disease, disability, infirmity or impairment. Preventive care is covered in certain circumstances, as specified in Topic 103 and in the Chapter 200 Series Handbooks.

Payment for necessary medical care and certain preventive services, as specified in Chapter 100, Topic 103, is made to participating providers when it is not available without charge or is not covered by health insurance or other liable third parties. As specified by rule, prior approval requirements may be imposed for some services.

Both fiscal considerations and good administrative practices require the imposition of certain limitations and controls on the kind and amount of medical care covered by the Department's Medical Programs. Careful review of the Handbook material will enable providers to identify specific program coverages and limitations.

Programs under which the Department is authorized to make payments include the following.

100.1 MEDICAL ASSISTANCE PROGRAM

The Illinois Medical Assistance Program is the program which implements Title XIX of the Social Security Act (Medicaid). It is administered by the Department of Public Aid under the Illinois Public Aid Code. The Department has statutory responsibility and authority for the formulation of medical policy in conformance with federal and State requirements.

100.2 KIDCARE PROGRAM

- = KidCare, a joint federal and state funded program, operates under Titles XIX and XXI of the Social Security Act, the Illinois Public Aid Code [305 ILCS 5/1-1 et seq.] and the Children's Health Insurance Program Act [215 ILCS 106] that authorize the Department of Public Aid to administer an insurance program to assist families in providing or purchasing health insurance benefits for their children. Through KidCare, the Department provides health benefits coverage to eligible children and pregnant women by providing health care benefits or by subsidizing the cost of private health insurance, including employer health insurance.

Four KidCare plans are encompassed by this Handbook:

- KidCare Assist Plan – This plan pays for a child's health care with no copayments or premiums from the participant.
- KidCare Share Plan – This plan pays for a child's health care with a low copayment due from the participant on certain services. Refer to Topic 114.
- KidCare Premium Plan - This plan requires participants to pay a low premium each month and a low copayment on certain services. Refer to Topic 114.
- KidCare Moms & Babies Plan – This plan covers pregnant women throughout pregnancy and babies for the first year of the baby's life with no copayments or premiums from the participant.

100.3 TRANSITIONAL ASSISTANCE PROGRAM (CITY OF CHICAGO) AND STATE FAMILY AND CHILDREN ASSISTANCE PROGRAM (CITY OF CHICAGO)

Medical coverage for participants in the Transitional Assistance Program and the Family and Children Assistance Program is administered by the Department of Public Aid under Article VI of the Illinois Public Aid Code (305 ILCS 5/6-1 et seq).

The Department has statutory responsibility and authority for the formulation of medical policy in conformance with State requirements. Both programs are funded by the State, with no federal participation.

100.4 QMB PROGRAM

The Department's Qualified Medicare Beneficiary (QMB) Program assists persons who are eligible for Medicare with the costs of Medicare cost-sharing, i.e. premiums, deductibles and coinsurance. QMB/Medicaid participants are enrolled in Medical Assistance as well as Medicare. QMB Only participants are eligible only for payment of Medicare cost sharing. The only items considered for payment for QMB Only participants are the deductible and coinsurance on services which are covered by Medicare.

100.5 STATE RENAL DIALYSIS PROGRAM

The State Renal Dialysis Program is operated by the Department under the authority of the Renal Disease Treatment Act (410 ILCS 430). This program covers the cost of renal dialysis services for eligible Illinois residents diagnosed with chronic renal failure.

100.6 STATE HEMOPHILIA PROGRAM

The State Hemophilia Program is operated by the Department under the authority of the Hemophilia Care Act (410 ILCS 420). This program provides assistance to eligible patients for antihemophilic factors, annual comprehensive visits and other outpatient medical expenses related to the disease.

100.7 STATE SEXUAL ASSAULT SURVIVORS EMERGENCY TREATMENT PROGRAM

The Illinois Sexual Assault Survivors Emergency Treatment Program is administered under the authority of the Sexual Assault Survivors Emergency Treatment Act (410 ILCS 70). This program provides payment for emergency outpatient medical expenses for sexual assault survivors who seek emergency services from a certified hospital and who are not eligible for Medical Assistance or KidCare and are not covered by other health insurance. It is not necessary for the assault to be proven in order for services to be covered.

For hospital certification to participate in the Sexual Assault Survivors Emergency Treatment Program, contact:

Illinois Department of Public Health
Office of Health Care Regulations
525 W. Jefferson, 5th Floor
Springfield, IL 62761
Telephone (217) 782-2913

=100.8 HEALTH BENEFITS FOR PERSONS WITH BREAST OR CERVICAL CANCER

The Department implemented Health Benefits for Persons with Breast or Cervical Cancer effective August 1, 2001. This program assists persons who have been screened under the National Breast and Cervical Cancer Early Detection Program administered by the Illinois Department of Public Health (DPH) and found to have breast or cervical cancer or a precancerous condition.

=100.9 HEALTH BENEFITS FOR WORKERS WITH DISABILITIES (HBWD)

The Department implemented Health Benefits for Workers with Disabilities effective December 1, 2001. This program assists persons with disabilities who wish to go to work, or to increase their earnings without the fear of losing Medicaid benefits.

101 PROVIDER PARTICIPATION

To receive payment for medical care, services and supplies provided to individuals eligible for any of the DPA Medical Programs, a provider must enroll and be approved for participation by the Department of Public Aid (DPA).

To enroll for participation, providers shall:

- C hold a valid, appropriate license where State law requires licensure of medical practitioners, agencies, institutions and other medical vendors;
- C be certified for participation in the Title XVIII Medicare program where federal or State rules and regulations require such certification for Title XIX Medicaid participation;
- C be certified for Title XIX Medicaid when federal or State rules and regulations so require;
- C provide enrollment information to the Department in the prescribed format (see Topic 201 in the Chapter 200 series), and notify the Department in writing promptly whenever there is a change in any such information which the provider has previously submitted;
- C provide disclosure, as requested by the Department, of all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions or other legal entities providing any form of health care service to eligible participants;
- C have a written provider agreement on file with the Department.

**PROVIDER
ENROLLMENT
PROCEDURE:**

To participate in the DPA Medical Programs, providers must complete a Provider Enrollment Application. To obtain an enrollment application, contact the Provider Participation Unit. Requests may be made by mail, e-mail or phone at:

e-mail: PPU@mail.idpa.state.il.us

Illinois Department of Public Aid
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

Telephone: (217) 782-0538
= Fax: (217) 557-8800

The Department will confirm that enrollment has been completed by sending a Provider Information Sheet to the provider. Further information on this process for each type of provider is described in Topic 201 in the Chapter 200 series.

101.1 PARTICIPATION REQUIREMENTS

To be approved for participation, a provider must agree to:

- C verify eligibility of the patient prior to providing each service (not applicable where prohibited by law, for example, emergency ambulance services or hospital emergency room services);
- C allow all patients the choice of accepting or rejecting medical or surgical care or treatment;
- C inform patients prior to providing a noncovered service for which the patient will be held financially liable, that payment for such service cannot be made by the Department;
- C provide supplies and services in full compliance with all applicable provisions of State and federal laws and regulations pertaining to nondiscrimination and equal employment opportunity, including, but not limited to:
 - C full compliance with Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color or national origin;
 - C full compliance with section 504 of the Rehabilitation Act of 1973 and Part 84 of Title 45 of the Code of Federal Regulations, which prohibit discrimination on the basis of handicap; and
 - C without discrimination on the basis of religious belief, political affiliation, sex, age or disability;
- C comply with the requirements of applicable federal and State laws and not engage in practices prohibited by such laws;
 - hold confidential, and use for authorized program purposes only, all Medical Assistance information regarding patients;
- C furnish to the Department, in the format and manner requested by it, any information it requests regarding payments for providing goods or services or supplies to patients by the provider, his or her agent, employer or employee;
- C provide services and supplies to patients in the same quality and mode of delivery as are provided to the general public, and charge the Department in amounts not to exceed the provider's usual and customary charges;
- C accept as payment in full the amounts established by the Department, except in limited instances involving allowable spenddown or co-payments, as described in Topics 113 and 114:
 - = C If a provider accepts an individual eligible for medical assistance from the Department as a Medicaid recipient, such provider must not bill, demand or otherwise seek reimbursement from that individual or from a financially responsible relative or representative of the individual for any service for which reimbursement would have been available from the Department if the provider had timely and properly billed the Department. For purposes of this subsection, "accepts" shall be deemed to include:
 - C an affirmative representation to an individual that payment for services will be sought from the Department;

- C an individual presents the provider with his or her medical card and the provider does not indicate that other payment arrangements will be necessary; or
- C billing the Department for the covered medical service provided an eligible individual
- C If an eligible individual is entitled to medical assistance with respect to a service for which a third party is liable for payment, the provider furnishing the service may not seek to collect from the individual payment for that service if the total liability of the third party for that service is at least equal to the amount payable for that service by the Department.
- C accept assignment of Medicare benefits for participants eligible for Medicare, when payment for services to such persons is sought from the Department;
- C in the case of long term care providers, assume liability for repayment to the Department of any overpayment made to the facility regardless of whether the overpayment was incurred by a current owner or operator or by a previous owner or operator.

These requirements are further detailed in 89 Illinois Administrative Code, Sections 140.11 through 140.12(k) and in relevant Topics throughout the Provider Handbooks.

101.2 TERMINATION OF PROVIDER PARTICIPATION

A participating provider may terminate participation in the Department's Medical Programs at any time, unless the provider has a contractual relationship with the Department which provides otherwise.

Exception: In the case of long term care providers, facilities must give written notice at least 60 days prior to the date of termination. For a complete description of these requirements, refer to the Handbook for Long Term Care Facilities.

Written notification of voluntary termination is to be sent to:

Illinois Department of Public Aid
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114.

The Department may terminate or suspend a provider agreement or a provider's eligibility to participate in the Department's Medical Programs pursuant to administrative proceedings. Department rules concerning the bases for such terminations or suspensions are set out in 89 Ill. Adm. Code 140.16. Department rules concerning administrative proceedings involving terminations or suspensions of medical vendors are set out in 89 Ill. Adm. Code 104, Subpart C.

The occurrence of a termination, either voluntary or involuntary, does not preclude the recovery of identified overpayments.

102.6 STATE HEMOPHILIA PROGRAM

Eligibility for this program is determined by the Department. Department staff conduct a financial evaluation and determine what the patient's participation fee, if any, will be. Once they are approved for coverage, participants are sent an application every fiscal year to reapply.

Applications are returned to:

Illinois Department of Public Aid
Attn: Hemophilia Program
P.O. Box 19129
Springfield, Illinois 62794-9129

No eligibility card is issued. Questions regarding applications or the eligibility of participants in the Hemophilia Program should be directed to the Bureau of Comprehensive Health Services at (217) 782-5565.

102.7 STATE SEXUAL ASSAULT SURVIVORS EMERGENCY TREATMENT PROGRAM

The Illinois Sexual Assault Survivors Emergency Treatment Program covers emergency medical expenses for sexual assault survivors who seek emergency services from a certified hospital and who are not eligible for Medical Assistance or KidCare and are not covered by other health insurance.

Another resource for these patients is:

Office of the Attorney General of Illinois
Crime Victims Compensation Program
100 W. Randolph St., 13th Floor
Chicago, IL 60601
Telephone (312) 814-2581

Other inquiries on this program should be directed to the Bureau of Comprehensive Health Services at (217) 782-5565.

=102.8 HEALTH BENEFITS FOR PERSONS WITH BREAST OR CERVICAL CANCER

Eligibility for this program is determined by the Department's Breast and Cervical Cancer (BCC) Eligibility Unit.

Evidence of eligibility for the Breast and Cervical Cancer Program is demonstrated by any of the following:

- C Form DPA 469, MediPlan Card (see Topic 108.1)
- C Form DPA 1411CF, Temporary MediPlan Card (see Topic 109)

C Form DPA 1411, Temporary MediPlan Card (see Topic 109)

Questions regarding the Breast and Cervical Cancer Program should be directed to the Department of Public Health's Women's Health Helpline at (888) 522-1282.

=102.9 HEALTH BENEFITS FOR WORKERS WITH DISABILITIES (HBWD)

Eligibility for this program is determined by the Department's Health Benefits for Workers with Disabilities (HBWD) unit in Springfield.

Evidence of eligibility for the Health Benefits for Workers with Disabilities Plan is demonstrated by any of the following:

- C Form DPA 469, MediPlan Card (see Topic 108.1)
- C Form DPA 1411CF, Temporary MediPlan Card (see Topic 109)
- C Form DPA 1411, Temporary MediPlan Card (see Topic 109)

Applications are returned to:

Health Benefits for Workers with Disabilities
P.O. Box 19145
Springfield, Illinois 62794-9145

Questions regarding applications or the eligibility of participants in the Health Benefits for Workers with Disabilities should be directed to (800) 226-0768.

=102.10 STATE AGENCY CONTACTS

Unless otherwise noted above, the contact procedures for inquiries to the State agencies responsible for determining eligibility are described below.

DHS local offices are organized and supervised by regions. When providers need to make contact with DHS regarding a participant, the DHS local office that serves the county in which the participant lives is to be contacted. In Cook County, providers should contact the appropriate neighborhood DHS local office. A listing of the DHS local offices is provided in General Appendix 1. A listing of the DHS regional offices is provided in General Appendix 2.

- = The Department of Children and Family Services (DCFS) has responsibility for administering its own cases. Eligibility for DCFS cases is determined by DHS staff located within the DCFS facility. When providers need to make contact with DCFS regarding a participant, the DCFS Regional Medical Liaison that serves the county in which the child is living is to be contacted. See General Appendix 3 for the Directory of DCFS Regional Offices.

Inquiries to DPA regarding eligibility for any medical program may be directed to (800) 842-1461.

=102.11 PRIOR AND RETROACTIVE COVERAGE

Once their coverage begins, participants in the Medical Assistance and KidCare programs receive monthly identification cards that document their eligibility and coverage limitations. See Topic 108 for examples and an explanation of the contents of the monthly MediPlan and KidCare Cards.

When they initially apply for coverage, Medical Assistance, KidCare Assist and KidCare Moms and Babies applicants may request that their coverage be backdated to cover services they may have received for up to three months prior to month of their application. The first time children are approved for KidCare Share or KidCare Premium, the children may be eligible for payment of medical services received from two weeks before the date of application until the date KidCare coverage begins

If a participant's request for retroactive coverage is granted, it is sometimes documented by a Temporary Identification Card. Examples and an explanation of Temporary Identification Cards can be found in Topic 109. Prior coverage may also be documented by a letter from the Department's central KidCare unit.

Retroactive coverage for Medical Assistance and KidCare Program participants is not always documented by a Temporary Identification Card or letter. If the participant cannot produce such documentation but requests that a provider bill the Department for medical services or items provided during the retroactive or prior coverage period, the provider may verify eligibility via the Recipient Eligibility Verification system (see Topic 131.2), the Department's toll-free AVRS Provider Health Care Hotline (1-800-842-1461), or by contacting the responsible administrative office as described in Topic 102.8.

- Physician Services
- Hospital Emergency Room Visits
- Transportation to the Hospital Emergency Room
- Drugs and Medical Supplies prescribed in the Emergency Room

The above services are covered only when they are directly related to an alleged sexual assault.

=103.8 HEALTH BENEFITS FOR PERSONS WITH BREAST OR CERVICAL CANCER

Participants in the Breast and Cervical Cancer Program receive the same medical benefits as the participants in the Medical Assistance Program. Refer to Topic 103.1.

=103.9 HEALTH BENEFITS FOR WORKERS WITH DISABILITIES (HBWD)

Participants in the Health Benefits for Workers with Disabilities Program receive the same medical benefits as the participants in the Medical Assistance Program. Refer to Topic 103.1.

3). Providers may contact the Department's Central KidCare Unit for further verification of questionable (yellow) KidCare Cards.





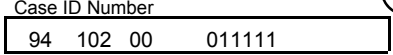
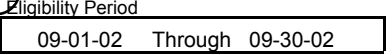
Providers may also utilize the Recipient Eligibility Verification (REV) system for verification of either Medical Assistance or KidCare eligibility, restrictions or co-payments. See Topic 131.2 for an explanation of the REV system.

If a provider suspects fraud or abuse regarding the use of a MediPlan or KidCare Card, the provider should call the Fraud and Abuse Hotline, at 1-800-252-8903.

108.4 PRIMARY PORTION (FRONT) OF IDENTIFICATION CARDS



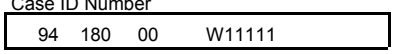
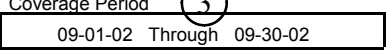
- = Reduced facsimiles of the primary portion (front) of the MediPlan Card and KidCare Card are provided on the next page. An explanation of the contents of the front portion of both cards is provided on the following pages. The item numbers that correspond to the explanations appear in small shaded circles, for example ⑥.

Reduced facsimile of the primary portion (front) of the MediPlan Card

  	 State of Illinois - Department of Public Aid MediPlan	 Case ID Number 94 102 00 011111	 Eligibility Period 09-01-02 Through 09-30-02
	CASELOAD: Z99 IMAGINARY, JANE DOE 45 ANYPLACE ROAD YOUR TOWN, IL 60000		
99999999	DPA 469 (R-1-90)	11-082302	IL 487-0234

Note: The seal of the State of Illinois appears in blue ink in the spot marked with a large X in a circle.

Reduced facsimile of the primary portion (front) of the KidCare Card

0006892F 	State of Illinois 	More KidCare Information: Call 1-866-468-7543 (TTY 1-877-204-1012)
	 Case ID Number 94 180 00 W11111	 Coverage Period 09-01-02 Through 09-30-02
OFFICE: 091 RPY IMAGINARY, JANE DOE 45 ANYPLACE ROAD YOUR TOWN, IL 60000		
PROVIDERS MAY COLLECT A CO-PAY FOR CERTAIN SERVICES. CO-PAYS ARE \$2.00 FOR DRUG PRESCRIPTIONS AND CERTAIN TYPES OF MEDICAL VISITS. NO CO-PAYS FOR IMMUNIZATIONS, WELL-CHILD VISITS, LAB AND RADIOLOGY SERVICES.		
DPA 469KC (R-7-98)	KC-08232002	IL 478-0234

Note: the KidCare Card is printed on canary yellow paper.

Reduced facsimile of the eligible persons portion (back) of the MediPlan Card

①	09-01-02 <small>Eligibility Period Through</small> 09-30-02	Case ID Number: 94 102 00 011111	00000111
②	IMAGINARY, JANE DOE 45 ANYPLACE ROAD YOUR TOWN, IL		
	ONLY THE FOLLOWING PERSONS ARE ELIGIBLE: ④		
	JANE D IMAGINARY MEDICAID	③ ID#:111111111 DOB: 04-01-51	⑤ TPL: B002
	IMOGENE IMAGINARY MEDICAID	ID#:222222222 DOB: 05-06-90	⑥
	FANTASY IMAGINARY MEDICAID	ID#:333333333 DOB: 06-03-95	TPL: A001

	TOTAL NUMBER OF ELIGIBLE PERSONS: ⑦ 3		
	11-082302		
	-Please see front of card for important information-		
	X		

Note: The seal of the State of Illinois appears in blue ink in the spot marked with a large X in a circle.

Reduced facsimile of the covered persons portion (back) of the KidCare Card

①	09-01-02 <small>Coverage Period Through</small> 09-30-02	Case ID Number: 94 180 00 W11111	0006892B
②	IMAGINARY, JANE DOE RPY 45 ANYPLACE ROAD YOUR TOWN, IL		
	ONLY THE FOLLOWING PERSONS ARE COVERED: ④		
	IMOGENE IMAGINARY	③ ID#:222222222 DOB: 05/06/90	⑥
	FANTASY IMAGINARY	ID#:333333333 DOB: 06/03/95	TPL: A001

	TOTAL NUMBER OF COVERED PERSONS: ⑦ 2		
	KC-08232002		
	-Please see front of card for important information-		
	ADDRESS CHANGED? CALL 1 - 866 - 468 - 7543 RIGHT AWAY (TTY 1 - 877 - 204 - 1012)		

FIELD OR ITEM	EXPLANATION
① Items Repeated from the Front of the Card	<p>The Eligibility/Coverage Period, Case ID Number and Case Name and Address which appear on the front of the card also appear in the three boxes on the back of the card. These items are explained in Topic 108.4. Also, if a message appears in the shaded box on the front of the MediPlan card, that same message appears in the shaded area on the back.</p>
② Name and Program Coverage Messages	<p>The first column in this area shows the name of every covered participant in the case. The order of the name is first name, middle initial and last name. The name, exactly as shown on the card, of the person to whom services were rendered should be entered as the patient name on the provider's claim.</p> <p>On the MediPlan card, a Program Coverage Message will be shown immediately below the name of each covered person. One or more of the following program coverage messages will appear as appropriate to the individual:</p> <p>GENERAL ASSISTANCE - specific program limitations are applicable and are specified on the card.</p> <p>GA - NO HOSPITAL - this is a category 07 case and hospital services are not covered.</p> <p>QMB ONLY - the individual listed is eligible for coverage as a Qualified Medicare Beneficiary (QMB) but is not eligible for Illinois Medical Assistance. The Department considers for payment only the deductible and coinsurance amounts on <u>Medicare</u> covered services. (This notation will also appear in the upper right shaded area on the front of the card.)</p> <p>QMB/MEDICAID - the individual is eligible to receive the full scope of covered services listed in Topic 103.1. This message indicates that the person is also eligible for coverage as a Qualified Medicare Beneficiary(QMB); therefore, Medicare is to be billed for covered services prior to billing the Department.</p> <p>MEDICAID - the individual is eligible to receive the full scope of covered services listed in Topic 103.1. If any restrictions to</p>

113 SPENDDOWN

The spenddown program provides Medical Assistance to participants who would otherwise be ineligible because of income or assets or both which exceed the Department's standards.

113.1 SPENDDOWN EXPLAINED

Spenddown is similar in concept to a patient deductible in a private insurance plan, with three major exceptions:

1. The participant's spenddown obligation is determined on a monthly basis. (Deductibles in most insurance plans are determined on an annual basis.)
2. The amount of the monthly spenddown obligation is based upon the participant's income and assets. (Most insurance plans have a standard deductible regardless of patient income.)
3. When spenddown is met in the middle of a month, the decision as to which bills are the patient's responsibility and which are the Department's is made chronologically based on date of service. (Most insurance plans base this decision on date of receipt of the bills.)

Although enrolled in the Medical Assistance program, spenddown participants do not automatically receive a MediPlan card each month. MediPlan cards are only issued for the month (or portion thereof) for which participants have demonstrated that incurred or paid medical expenses equal the spenddown obligation by presenting medical bills and receipts to the local DHS office. In the case of participants who have private insurance or other Third Party Liability (TPL) coverage, that portion of the medical bills and receipts which is paid by the TPL resource is not counted toward meeting the spenddown obligation.

Because the participant's eligibility can be determined only after he or she receives medical bills or receipts demonstrating that the spenddown obligation has been met, it is not unusual for the MediPlan card to be issued several months after the month it covers.

- = If a provider accepts an individual as a Medicaid participant, all medical charges up to the amount of the spenddown obligation are the participant's responsibility.

For example

- if a provider renders a service to a participant with a \$300 spenddown, and the Department's maximum rate for the service is \$275, and the private pay rate is \$350, the provider may only bill the participant for the \$300 spenddown amount. The provider may not bill the participant at the private pay level, or
- a participant's spenddown obligation is \$60, and he or she receives a medical service for which the provider charges \$80 but for which the Department's maximum rate is \$65. In this instance, the spenddown obligation would be satisfied by the provider's charges, the participant would be responsible for the

\$60 spenddown obligation and the Department would pay \$5. The participant could not be held responsible for the unpaid balance.

113.2 SPLIT-BILL DAY

Responsibility for bills on the day the spenddown obligation is met is often shared between the patient and the Department. This is referred to as “split-bill day”. The local DHS office will notify the participant that spenddown has been met, which bills the participant is responsible for paying and which bills should be sent to the Department for payment. The local DHS office will send Form DPA 2432, Split-Billing Transmittal, to the participant for each provider who is eligible for payment from the Department on the split-bill day. The participant is responsible for taking these forms to the medical provider. Upon request, the local DHS office may send a Form DPA 2432 directly to the medical provider.

The Split-Billing Transmittal is issued only for those providers who are eligible for payment for services rendered on the split-bill day. No Form DPA 2432 will be issued for those bills which are totally the responsibility of the patient.

When any services are billed for a date that is determined to be a split-bill day, the Split-Billing Transmittal must be attached to the claim. Providers can determine the need for a Form DPA 2432 when billing by viewing the MediPlan Card. If there is a split-bill day, the MediPlan Card will contain a message regarding the need for Form DPA 2432 and identifying the service date affected.

If services were provided on the split-bill day and a Form DPA 2432 has not been received, the provider should determine whether or not one has been issued. This can be accomplished by viewing the notice sent to the participant or by contacting the local DHS office. However, no billing should be submitted to the Department unless Form DPA 2432 has been received and attached to the Department claim. Unless a Form DPA 2432 has been received, the participant remains responsible for the charges incurred on the beginning date of eligibility.

Specific instructions for completing a claim form to which Form DPA 2432 is attached can be found in the Chapter 200 Appendices.

enters the patient copayment amount on the claim in error, as a patient contribution or a third-party payment, this will cause the Department's payment to be reduced.

=114.2 COPAYMENTS FOR MEDICAL ASSISTANCE PROGRAMS

Participants in the Department's Medical Assistance Programs may be subject to a copayment as described below.

=114.21 Fee-For-Service Copayments

A copayment may be charged to an adult participant in the Medical Assistance Program for each fee-for-service office visit to a physician, chiropractor, podiatrist or optometrist and for prescription drugs (legend drugs) received through a pharmacy, with certain exceptions. No provider of these services may deny service to a participant who is eligible for service on account of the participant's inability to pay the cost of the copayment. See Appendix 13 for specific codes subject to the copayment. For further information, refer to 89 Ill. Adm. Code 140.402.

The Department will automatically deduct the copayment on applicable services from the payable amount and will report the deduction on the point-of-sale electronic billing system for pharmacies and on the remittance advice for all affected providers. When billing the Department, providers should continue to bill their usual and customary charge and should not report the copayment on the claim or electronic submission.

Reimbursement and copayments under the KidCare Share Plan and KidCare Premium Plan are not subject to this policy. See Topic 114.1 for an explanation of copayments under KidCare Share and Premium.

=114.22 Copayments for Inpatient Hospital Stays

A copayment may be charged to an eligible participant for certain inpatient hospital stays. The Department deducts such copayments when calculating the amount of its payment to the hospital. For further information, refer to 89 Ill. Adm. Code 148.190.

114.3 MEDICARE CO-INSURANCE AND DEDUCTIBLES

Medical Program participants may not be charged for Medicare co-insurance and deductibles, regardless of whether the Department pays all, some or none of the charges. Refer to Topic 120.12 for further details.

114.4 STATE RENAL DIALYSIS PROGRAM PARTICIPATION FEES

Participants in the State Renal Dialysis Program may be responsible for payment of a portion of the cost of covered dialysis services. This is referred to as the patient's monthly participation fee. It is determined by the Department on an annual basis.

The Renal Dialysis Center is notified of the amount in writing, via a computer-generated Eligibility Report for Dialysis Patients.

The renal dialysis center may charge State Renal Dialysis Program patients for services up to the amount of the participation fee. Such charges will be automatically deducted from the patient's monthly dialysis claims submitted to the Department.

Other than the monthly participation fee, dialysis centers may not charge a State Renal Dialysis Program participant for any covered dialysis service for which a claim is submitted to the Department.

114.5 STATE HEMOPHILIA PROGRAM PARTICIPATION FEES

Participants in the State Hemophilia Program may be responsible for payment of a portion of the cost of covered services. This is referred to as the patient's annual participation fee. It is determined on an annual basis. Both the participant and the Hemophilia Center are notified of the amount in writing, via a letter from the Department.

Providers may charge State Hemophilia Program patients for covered services up to the amount of the participation fee. Such charges will be automatically deducted from the first bill or bills submitted to the Department.

Once the patient's annual participation fee has been met, a State Hemophilia Program participant may not be charged for any covered service for which a claim is submitted to the Department.

114.6 LONG TERM CARE FACILITY GROUP CARE CREDITS

Participants in the Department's Medical Programs who reside in Long Term Care (LTC) facilities may be responsible for payment toward the cost of covered services. This payment is referred to as the group care credit. It is determined for each resident on a monthly basis by the DHS local office. DHS notifies the resident of the amount in writing. Refer to Topic C-212 in the Long Term Care Provider Handbook for an explanation of this process.

Facilities may charge residents for covered LTC services up to the maximum monthly payment rate established by the Department for those services, or their group care credit that month, whichever is less. Such charges will be automatically deducted from the amount that would otherwise be paid to the LTC facility by the Department.

Refer to Topic C-230 in the Long Term Care Provider Handbook for a listing of services covered by the Department's monthly payment to the facility.

114.7 HOSPICE PATIENT GROUP CARE CREDITS

When a hospice patient resides in a Long Term Care facility, the hospice is responsible for payment of the LTC room and board charges. In this case, the patient's group care credit (if any) described in Topic 114.5 is automatically deducted from amount that would otherwise be paid to the hospice by the Department. Refer to Chapter 200 of the Handbook for Hospice Providers for an explanation of this process.

- If the Medicare service is also covered by the Medical Assistance program, the amount of Medicare payment is compared with the Department's maximum rate for the service. The Department will pay the deductible and coinsurance to the extent that such payment plus Medicare's payment does not result in an amount that exceeds the Department's maximum rate. If the payment from Medicare exceeds the Department's maximum rate for the service, the claim will appear on the Remittance Advice as approved, but no payment will be made.

120.2 HEALTH INSURANCE

If the provider identifies health insurance that is not shown on the Department's medical card, or the insurance coverage shown on the card is no longer in force, notification is to be made to the address below.

Illinois Department of Public Aid
Third Party Liability Section
1130 South Sixth Street
P.O. Box 19120
Springfield, Illinois 62794-9120
Telephone: (217) 524-2490
Fax: (217) 557-1174

120.3 PERSONAL INJURY CASES

It is the responsibility of the provider to notify the Department of any request from attorneys, insurance carriers, or participants for release of participant information.

Address requests pertaining to Cook County and out-of-state residents to:

Illinois Department of Public Aid
Technical Recovery Unit
401 South Clinton, 4th Floor
Chicago, Illinois 60607
Telephone: (312) 793-3528

Address requests for all other Illinois residents to:

Illinois Department of Public Aid
Technical Recovery Unit
808 South College Street
Springfield, Illinois 62704
Telephone: (217) 785-8711

120.4 EXCEPTION FOR BILLING OTHER PAYMENT SOURCES FOR PREVENTIVE SERVICES FOR CHILDREN AND PREGNANT WOMEN

- = Physicians providing services to women with a diagnosis of pregnancy or preventive services to children are not required to bill a client's private insurance carrier prior to billing the Department. Charges may be billed immediately to the Department. The Department will collect information regarding paid services and assume responsibility for the collection of the third party benefits.

In making the decision to bill the Department first, the provider should be cognizant of the possibility that the third party payor might reimburse the service at a higher rate than the Department, and that once payment is made by the Department, no additional billing to the other third party payor is permitted.

133 REFUNDS

Although the Adjustment process in Topic 132 should generally be used whenever incorrect payment has occurred, there may be instances in which a provider considers it necessary to refund an overpayment to the Department.

To ensure that a refund or returned check is processed accurately and that the Department's records are adjusted appropriately, special care should be taken to ensure that correct and sufficient information is provided. For all types of providers other than Long Term Care facilities, if questions arise about the refund process, if the required documentation is not available or if the process described below does not seem to fit the situation requiring the refund, the provider should contact a billing consultant at (217) 782-5565. LTC providers should contact the Bureau of Long Term Care at (217) 782-0545 for instructions in any situation requiring a refund.

Procedure: With the refund check, the provider should submit a copy of the appropriate Adjustment form. Refer to General Appendix 6 for instructions on completing Adjustment forms. The provider should also submit a copy of the Department-generated Remittance Advice which was received with the incorrect payment or overpayment. The Remittance Advice should be marked to clearly indicate which payments are being refunded. Following these instructions will ensure that the Department has all of the information necessary for processing the refund and adjusting the Department's claims history files.

The provider must ensure that the total of all the individual service adjustments equals the refund check amount. Verification of the Department's receipt of the refund and processing of the adjustments will be reported on a future Remittance Advice.

- = When a refund is made via a check written on the provider's own bank account, the check should be made payable to the Illinois Department of Public Aid. The provider should not mix payment refunds for various provider types on one check, i.e., hospital and non-institutional services. Separate refund checks are to be submitted because the refunds will be processed by the department in two separate refund systems

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Refund checks for services billed on the UB92 should be sent to the following address:

Illinois Department of Public Aid
Hospital Adjustment Unit
P. O. Box 19128
Springfield, Illinois 62793-9128
Telephone: (217) 782-5565

Pharmacy refund checks should be sent to the following address:

Illinois Department of Public Aid
Drug Unit
P. O. Box 19117
Springfield, Illinois 62794-9117
Telephone: (217) 782-5565

Non-Institutional Provider refund checks should be sent to the following address:

Illinois Department of Public Aid
Adjustment Unit
P. O. Box 19101
Springfield, Illinois 62793-9101
Telephone: (217) 524-4597

Third Party Liability (TPL) refund checks should be sent to the following address:

Illinois Department of Public Aid
Bureau of Collections, Third Party Liability
P. O. Box 19140
Springfield, Illinois 62794-9140
Telephone: (217) 785-1753

GENERAL APPENDIX 5

ERROR CODE EXPLANATIONS

ERROR CODE	MESSAGE	EXPLANATION
= A22	MORE SPECIFIC DIAGNOSIS REQUIRED	A UB92 claim was submitted with an obsolete diagnosis code(s). Review and resubmit claim with the appropriate diagnosis code(s) that are in effect for the beginning date of service being billed.
= A23	MORE SPECIFIC PROCEDURE CODE REQUIRED	A UB92 claim was submitted with an obsolete procedure code(s). Review and resubmit claim with the appropriate procedure code(s) that are in effect for the beginning date of service being billed.

NOTE: The acronym FL used throughout this appendix means Form Locator. This is a description created by HCFA to identify an item on form UB-92.

C01	NDC/ITEM NUMBER NOT ON FILE	A claim was submitted for a service, item or NDC which is not in the DPA reference database. Refer to provider records to verify the identification number or code for the service, item or NDC. If an incorrect number was submitted, rebill with the correct item number.
C02	ADDITIONAL INFORMATION REQUIRED	<p>Insufficient information was provided to process the claim for payment. If the claim was for a covered service, submit a new claim with a brief service description shown in the procedure description field. Also, attach the appropriate report (Operative, Radiology, Laboratory, Pathology, etc.). If no formal report is available, attach a typed narrative description of the service/procedure.</p> <p>If the claim was for a covered drug item, rebill showing the drug name/form/strength/quantity in the procedure/description field, or if additional space is required, the information may be attached to the claim.</p>
C03	ILLOGICAL QUANTITY	<p>Pharmacy billing: A Pharmacy service was submitted for a quantity less than the minimum allowed for the National Drug Code billed. If the quantity was entered incorrectly, rebill on a new claim with the correct information entered in the appropriate fields. If the quantity was billed correctly, contact the Pharmacy Prior Approval unit at 800-252-8942.</p> <p>All other billing: A claim was submitted for a service which does not require any entry in the Days/Units field of the claim form. Rebill and leave this field blank. If the procedure/service was performed more than once on the same date of service, use the corresponding "unlisted" code for the additional service(s). A description of the service(s) must be shown on the claim or an attachment.</p>
C04	PRICING REVIEW	The claim has been suspended for Department review. If no response is received within 30 days, review the claim to see if a description or attachment is needed. Rebill including the attachment. The final status of the service will be reported on a future Remittance Advice.

- | | | |
|-----|---|---|
| C06 | NDC/ITEM
NUMBER
INVALID ON
DATE OF
SERVICE | A claim was submitted with an NDC/item number which was not shown as a valid code on Department files on the date of service. If either the NDC/item number or the date of service was submitted incorrectly, rebill the service by submitting a new claim including the correct NDC/item number and date of service. |
| CO7 | LOCAL TAX
AVAILABLE FOR
TUBERCULOSIS
TREATMENT | Review FL67 - 77 (Diagnosis Code). The participant resides in a jurisdiction which levies a special tax for treatment of Tuberculosis. The local Department of Public Health office should be contacted for specific billing instructions. If funds are exhausted or if the county states they will only pay for certain services, contact a UB-92 billing consultant for assistance. |

P19	SERVICES NOT ALLOWED BY PROVIDER SERVICES	<p>NIPS: The Bureau of Comprehensive Health Services has caused the service to be suspended for special review. The service was then rejected as inappropriate for payment. Do not rebill.</p> <p>UB-92: The provider is delinquent in submitting their cost report to the Department. No payments will be issued until receipt of the aforementioned report. Please contact a UB-92 billing consultant at (217) 782-5565.</p>
P20	RX PRACTITIONER NOT IDENTIFIED	A service was received with the Prescribing Practitioner field blank. A new claim with the missing data included should be submitted.
P24	NO DELIVERY PRIVILEGES ON FILE	A claim for a prenatal visit was received, but the Department files do not indicate that the physician rendering the service has either delivery privileges or an agreement with a physician who has delivery privileges. Contact the Provider Participation Unit to obtain the necessary forms to identify the provider's delivery privileges or agreement with another physician who has delivery privileges. See Chapter 100, Addresses and Telephone Numbers.
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P39	Deleted	
P40	GROUP CARE ITEM ONLY	<p>The item or service which was billed is restricted for payment to residents of a Long Term Care (LTC) Facility. Department records indicate that the participant was not a resident of an LTC Facility on the date of service. Review the medical records and the rejected claim to insure that the item or service, the resident, and the date of service were correct. If an error was made the service may be rebilled on a new claim.</p> <p>If the provider believes that the claim was billed correctly, a new claim should be completed and sent with a letter of explanation in a Special Handling Envelope (DPA 2248).</p>

P49	LIMITED ENROLLED PROVIDER/ CONTACT DEPARTMENT	<p>NIPS: The provider has submitted a claim for services when he has been enrolled with the Department in a "limited" status. Contact the Provider Participation Unit. See Chapter 100, Addresses and Telephone Numbers.</p> <p>UB-92: Provider is from a non-bordering state and is submitting a claim for less than \$150.00. Contact the UB-92 Billing Unit at 217-782-5565 for assistance.</p>
P50	REVIEW OF PROVIDER INFORMATION	The claim has been temporarily suspended for Department review. The final status of the claim will be reported on a future Remittance Advice. Do not rebill.
P52	MONIES DIVERTED TO IRS FOR TAX LEVY	The Department has been ordered to re-direct the provider's warrants to IRS because of an outstanding tax levy, wage garnishment, etc.
P59	CARE NOT APPROPRIATE FOR CHILDREN'S HOSPITAL	<p>The claim was submitted for a children's hospital where:</p> <ul style="list-style-type: none"> the participant was 18 years of age or older on the date of admission, or the participant was under age 18, but Category of Service 21 (Psychiatric) or 22 (Rehabilitation) was used, or the primary diagnosis code was in the range 290 through 302 or 306 through 319, or the DRG code is in the range 370 through 384 or the DRG code is 391. <p>Review the medical records and the coding on the rejected claim for correctness. If an error is found, submit a correct UB-92. If assistance is needed, contact a hospital billing consultant.</p>
P60	CARE NOT APPROPRIATE FOR ADULT HOSPITAL	<p>The claim was submitted with an adult hospital number and the patient is under age 18 on the date of admission and either</p> <ul style="list-style-type: none"> the Category of Service is 20 or 23 and the DRG code is not in the range 370 through 384 or is not code 391, or the Category of Service is 24, 25 or 26 and the Principal Diagnosis code is not in the range of 630 - 677 or V22, V23 or V28.

R36	PART B SERVICE- BILL MEDICARE	The Department's records show that the participant was eligible for Part B Medicare coverage on the date of service. The claim submitted did not indicate that it had been previously submitted to Medicare. The claim should be submitted to the Medicare Part B Carrier for processing. If the claim was previously submitted to Medicare, attach a copy of the Explanation of Medicare Benefits (EOMB) to the claim when it is rebilled. If the claim was submitted to Medicare but no response was received, contact the Medicare Carrier to determine the disposition of the claim.
=		
R39	RECIPIENT HAS PREPAID FULL SERVICE PLAN	A claim was submitted for services rendered to a participant who is a member of a Managed Care Organization (MCO) with full service coverage. Do not rebill. Contact the MCO for payment.
R41	PRIOR APPROVAL NOT ON FILE	<p>A claim requiring a prior approval was received but no corresponding prior approval could be found in the Department's records.</p> <p>If the provider's records contain an approved prior approval request for the service, review the claim to ensure that it contains the correct item number, date of service and Recipient Identification Number. If not, submit a new claim form with corrected information.</p> <p>If the provider has not requested a prior approval, or if the prior approval contains incorrect information, contact the Prior Approval Unit for assistance.</p>
R42	PRIOR NUMBER NOT ON FILE FOR DATE OF SERVICE	A claim was received with a prior approval which does not cover the date of service. Review records to ensure that the date of service submitted is correct. If the date is incorrect, submit a correct claim to the Department. If the date of service is correct but does not match the date or date range covered in the existing prior approval, contact the Prior Approval Unit for assistance.
R43	HCPCS PROCEDURE CODE REQUIRED	The procedure code billed is not a valid HCPCS code according to Department files. The service may be rebilled on a new claim form by completing the entire service section using a valid HCPCS Level I (CPT IV) or Level II/III (alpha-numeric) procedure code.

R45	OBSOLETE CODE - NEW HCPCS CODE REQUIRED	A claim was received with a Level II/III alpha/numeric HCPCS code which is obsolete according to Department files. Refer to the coding source used in preparing bills to ensure that it is the most recent edition. If an incorrect code was used, rebill on a new claim form by completing the entire service section with the correct data. If no error is found, forward a new claim form and a letter documenting the source of the rejected code in a Special Handling Envelope (DPA 2248).
R46	OBSOLETE CODE - SEE CURRENT CPT IV	A claim was received with a procedure code that is obsolete. Verify that the most recent edition of CPT IV is being used. If an incorrect code was used, rebill the service on a new claim form by completing the entire service section with the correct data. If no error is found, forward a new claim form with the service section completed and a letter documenting the source of the rejected code in a Special Handling Envelope (DPA 2248).
R48	TYPE OF CARE REQUIRES AUTHORIZA- TION	Review FL56P (Category of Service/Bill Indicator line). When the category of service is coded either 37, 38 or 39, an authorization form must be attached to the claim. For authorization, contact the Bureau of Long Term Care. For billing problems, contact a billing consultant at (217) 782-5565.
R50	REVIEW OF RECIPIENT	The claim has been temporarily suspended for Department review. Do not rebill. The final status of the claim will be reported on a future Remittance Advice.
R51	REVIEW OF CHRONIC RENAL DIALYSIS INFORMATION	The claim has been temporarily suspended for Department review. Do not rebill. The final status of the claim will be reported on a future Remittance Advice.

T40	MEDICARE BENEFICIARY HAS ADDITIONAL TPL	A claim was received for a participant covered by third party insurance in addition to Medicare B, but no TPL information was submitted with the crossover claim. The third party should be billed as a secondary payer after Medicare B has approved the charges. If the third party makes payment and an unpaid amount remains, submit a claim form with the Medicare EOMB and a TPL EOB verifying TPL information. If the third party makes no payment or no liability is in force on the date of service, submit documentation of this fact and the Medicare EOMB with the claim.
T41	MISSING MEDICARE PAYER	Review FL56P (Category of Service/Bill Indicator line). If the bill indicator is "X" (Medicare) and TPL code 909 or 910 is present in FL56, then the first characters of the payer line must be either Medicare or code 98910.
=		
T46	TPL INVALID ON ILLINOIS MEDICAID LINE	For UB92 billing, review form locators 54 and 56. There should be no prior payment and/or TPL code across from the Illinois Medicaid line. Correct and submit a new claim.
T50	REVIEW OF TPL INFORMATION	The claim has been suspended for Department review. The final status will be reported on a future remittance advice.

ADJUSTMENT PREPARATION AND MAILING INSTRUCTIONS

- DPA 1410 (Pharmacy Adjustment),
- DPA 2249 (Hospital Adjustment), and
- DPA 2292 (NIPS Adjustment)

The form should be either typewritten or legibly hand printed in ink. Any required item left blank may result in the adjustment form being returned to the provider for proper completion. The following explanation and instructions for completion correspond with the numbered entry fields on the adjustment forms:

1. DOCUMENT CONTROL NUMBER - Leave blank. This field will be completed by the Department.
2. PROVIDER NAME (and) ADDRESS - Enter the provider's name and address as it appears on the Provider Information Sheet.
3. PROVIDER NUMBER - Enter the provider's number exactly as it appears on the Provider Information Sheet. Do not use any spaces, hyphens, etc.
4. PAYEE - Enter the single digit number of the payee to which payment was made. Payees are coded numerically on the Provider Information Sheet.
5. PROVIDER REFERENCE - Completion of this field is optional; however, the numerical and/or alphabetical characters (up to a maximum of 10) utilized in the provider's accounting system for identification purposes may be entered. If an entry is made in this field, the information will be reported back to the provider on a future remittance advice reporting the disposition of the adjustment.
6. VOUCHER NUMBER - Enter the eight digit identifier which appears in the lower left corner of the Remittance Advice which reported payment of the service.
- = 7. DOCUMENT CONTROL NO. - Enter the Document Control Number which appears in the first column on the left of the Remittance Advice.
8. SERV. SECT. (Service Section) (NIPS and Pharmacy only) - Enter the appropriate number to identify the specific Service Section to be adjusted. This number appears on the Remittance Advice in the first column on the left below the participant's name.
9. DATE OF SERVICE - Enter the date of service in the MMDDYY format as it appears on the Remittance Advice for the particular service/item to be adjusted. For UB-92 billers, for claims for more than one day of service, enter the last paid

date of service from the remittance advice. For NIPS adjustments, a separate form is required for each date of service.

10. ITEM OR SERVICE (NIPS only), NDC (Pharmacy only) - NIPS providers enter the procedure code, pharmacy providers enter the NDC for the item or the service to be adjusted as it appears on the Remittance Advice. UB-92 billers leave blank.
11. RECIPIENT NAME - Enter the patient's name exactly as it appears on the Remittance Advice (first and last name).
12. RECIPIENT NUMBER - Enter the nine digit recipient number as it appears on the Remittance Advice.
13. DATE OF BIRTH - Enter the patient's date of birth in the MMDDYY format as it appears on the Remittance Advice.
14. ADJ. (Adjustment) TYPE - On all provider-initiated adjustments, one of the following codes must be entered to identify the reason the adjustment is being requested:
 - 01 Third Party Collection - This code is to be used when payment is received for a claim from another source after payment was made by the Department. Repayment must be made to the Department of any amount received from another source up to the amount received from the Department.
 - 02 Billing or payment error on an individual Service Section detected by the provider or, for UB-92 billers, when a claim has been paid in error. This code is to be used when the provider determines:

Payment was made based on erroneous information entered in a Service Section of the claim such as an incorrect procedure code or charge;

or

A Service Section was paid in error, e.g., a duplicate payment, a payment made on behalf of a patient unknown to the provider, etc.
 - 03 Reconsideration - This code is to be used if the provider wants to ask that the Department review and determine whether special circumstances may permit a change in the amount paid for a specific service. This adjustment type does not apply to UB-92 billers.

- ② Provider Reference - The reference number (up to 10 characters) is shown if one was entered on the invoice by the provider.
- ③ Category of Service - The numeric code for the category of service will be printed in the third column of the remittance advice. All claims for the same category of service will be grouped together. The categories will appear in the sequence shown below although a remittance advice may not contain all categories of service.

20 - Inpatient Hospital Services (General)
21 - Inpatient Hospital Services (Psychiatric)
22 - Inpatient Hospital Services (Physical Rehabilitation)
23 - Inpatient Hospital Services (End Stage Renal Disease)
24 - Outpatient Hospital Services (General)
25 - Outpatient Hospital Services (End Stage Renal Disease)
26 - General Clinic Services
27 - Psychiatric Clinic Services (Type A)
28 - Psychiatric Clinic Services (Type B)
29 - Clinic Services (Physical Rehabilitation)
35 - Subacute Alcoholism and other Drug Abuse
37 - Skilled Care - Hospital Residing
38 - Exceptional Care - Hospital Residing
39 - DD/MI - Hospital Residing
60 - Hospice

- ④ Date of Service - For inpatient services, the date appearing in the first line is the first day included in that particular claim. The date appearing in the second line is the last day included in that particular claim. For outpatient or clinic services, the date appearing in the first line is the actual date of service.
- ⑤ Amount Billed - This column reflects the amount of "Total Covered Charges" on the UB-92. NOTE: For Medicare crossovers, the amount shown will be the deductible and/or co-insurance.
- ⑥ Amount Allowed - This is a multi-purpose column which will show the amount of payment allowed by the Department. For late ancillary claims, the Amount Allowed field will be blank because no payment is being made.

When a check or warrant has been returned, this field will show the amount of the check or warrant.

For credit adjustments, the Amount Allowed field will show the actual amount being recovered on the particular voucher.

- ⑦ Status - One of the following code entries will appear explaining the action taken on the net charge made:

- = PD - paid;
RD - paid at a reduced rate to conform with Department standards
RJ - rejected - no payment;
SS - suspended - action pending.

For each adjustment or late ancillary claim, one of the following codes will appear:

DB - debit
CR - credit
RT - checks returned by the provider
PS - a processed credit adjustment for which no payable claims are available. When this occurs, the amount of the credit will be taken from a subsequent payment(s). The subsequent application of this credit will appear with the same Document Control Number and a status of CR.

- ⑧ Error Code - The remittance advice will report error codes to provide further information regarding the status of a claim or service. A three character code, one alpha character and two numeric characters, will appear to indicate the specific error which caused the action taken by the Department. (See General Appendix 5 for error code details.)

When the "Status" entry is RJ, an error code will appear to identify the reason the claim was rejected. When the "Status" entry is SS, an error code will be shown to indicate the reason the claim was placed in suspense.

- ⑨ Patient Name - This identifies the patient to whom the billed services were provided.

NOTE: The words "Mass Adjustment" will appear rather than a patient's name when an Adjustment Form DPA 2249 is processed to correct several claims or for an adjustment not related to specific claims, for example, to report a cost reconciliation.

- ⑩ Recipient Number - This indicates the unique nine-digit number entered on the claim for that patient.

- ⑪ Item or Service - Based on the category of service, this column will show one of the following entries:

- DAYS followed by the applicable number of days which appeared on the

Reduced Facsimile of Form DPA 194-M-1 for UB-92 Providers

PROVIDER NUMBER 480000000000	TYPE 30	ILLINOIS DEPARTMENT OF PUBLIC AID REMITTANCE ADVICE			DATE 05/02/02	PAGE 1		
VENDOR COPY 1								
DOCUMENT CONTROL NUMBER RECIPIENT NAME	PROV REFERENCE RECIPIENT NUMBER	CAT SERV	DATE OF SERVICE	NDC/ITEM OR SERVICE	AMOUNT BILLED	AMOUNT ALLOWED	STAT	ERROR CODES
RECONCILABLE ADJUDICATED INVOICES								
1	2	3	4	5	6	7	8	
= 210801543242 JANE IMAGINARY	7414 111111111	20	040502 040602	DAYS 2	1645.00	963.90	PD	F01
9	10			11				
PAYMENT REDUCED								
PROVIDER SUMMARY								
TOTAL BILLED					1645.00			
TOTAL REJECTED					42.00			
AMOUNT REDUCED					639.10			
AMOUNT SUSPENDED								
TOTAL TPL					0.00			
TOTAL CREDITS								
TOTAL DEBITS								
PAYABLE AMOUNT					963.90			
RETURNED CHECK								
IF REMITTANCE TOTAL IS LESS THAN \$1.00, NO PAYMENT IS MADE								
VOUCHER NUMBER 21224123		PROVIDER MAILING ADDRESS 4800000000001111 ANONYMOUS HOSPITAL 9876 SCENIC AVENUE ANYTOWN, IL 66111			REMITTANCE TOTAL 963.90			
PLEASE REFER TO THIS 480 NUMBER AND TO THE DOCUMENT CONTROL NUMBER ON ALL CORRESPONDENCE 1 OF 1								

DPA 194-M-2 (R-4-91)

Reduced Facsimile of Form DPA 194-M-1 for NIPS Providers

PROVIDER NUMBER 03600000	TYPE 10	ILLINOIS DEPARTMENT OF PUBLIC AID REMITTANCE ADVICE				DATE 05/02/02	PAGE 1		
VENDOR COPY 1									
DOCUMENT CONTROL NUMBER RECIPIENT NAME	PROV REFERENCE RECIPIENT NUMBER	CAT SERV	DATE OF SERVICE	NDC/ITEM OR SERVICE	AMOUNT BILLED	AMOUNT ALLOWED	STAT	ERROR CODES	

ADJUDICATED INVOICES									
<div style="border: 1px solid black; border-radius: 50%; width: 20px; height: 20px; text-align: center; line-height: 20px; margin: 5px auto;">1</div> =210701054321 <div style="border: 1px solid black; border-radius: 50%; width: 20px; height: 20px; text-align: center; line-height: 20px; margin: 5px auto;">3</div> JANE IMAGINARY <div style="border: 1px solid black; border-radius: 50%; width: 20px; height: 20px; text-align: center; line-height: 20px; margin: 5px auto;">5</div> SECTION 01	776414 111111111	<div style="border: 1px solid black; border-radius: 50%; width: 20px; height: 20px; text-align: center; line-height: 20px; margin: 5px auto;">2</div> <div style="border: 1px solid black; border-radius: 50%; width: 20px; height: 20px; text-align: center; line-height: 20px; margin: 5px auto;">4</div>	<div style="border: 1px solid black; border-radius: 50%; width: 20px; height: 20px; text-align: center; line-height: 20px; margin: 5px auto;">6</div> 01	<div style="border: 1px solid black; border-radius: 50%; width: 20px; height: 20px; text-align: center; line-height: 20px; margin: 5px auto;">7</div> 040502 PAYMENT REDUCED	<div style="border: 1px solid black; border-radius: 50%; width: 20px; height: 20px; text-align: center; line-height: 20px; margin: 5px auto;">8</div> 37205	<div style="border: 1px solid black; border-radius: 50%; width: 20px; height: 20px; text-align: center; line-height: 20px; margin: 5px auto;">9</div> 1603.00	<div style="border: 1px solid black; border-radius: 50%; width: 20px; height: 20px; text-align: center; line-height: 20px; margin: 5px auto;">10</div> 935.00	<div style="border: 1px solid black; border-radius: 50%; width: 20px; height: 20px; text-align: center; line-height: 20px; margin: 5px auto;">11</div> RD	<div style="border: 1px solid black; border-radius: 50%; width: 20px; height: 20px; text-align: center; line-height: 20px; margin: 5px auto;">12</div> F01
<div style="border: 1px solid black; padding: 5px; display: inline-block;">TPL INFORMATION</div>									
210701054322 JANE IMAGINARY SECTION 01	776414 111111111		01	040502 SERVICES INVALID FOR RECIPIENT SEX	54150	42.00		RJ	R16
<div style="border: 1px solid black; padding: 5px; display: inline-block;">ADJUSTMENT INFORMATION</div>									
<div style="border: 1px solid black; border-radius: 50%; width: 20px; height: 20px; text-align: center; line-height: 20px; margin: 5px auto;">13</div> PROVIDER SUMMARY TOTAL BILLED TOTAL REJECTED AMOUNT REDUCED AMOUNT SUSPENDED TOTAL TPL TOTAL CREDITS TOTAL DEBITS PAYABLE AMOUNT RETURNED CHECK IF REMITTANCE TOTAL IS LESS THAN \$1.00, NO PAYMENT IS MADE					1645.00	42.00 668.00	0.00	935.00	

VOUCHER NUMBER 2122D123	PROVIDER MAILING ADDRESS 0360000001111111 ANONYMOUS PHYSICIAN GROUP, INC. 9876 SCENIC AVENUE ANYTOWN, IL 66111	<div style="border: 1px solid black; padding: 5px; display: inline-block;"> REMITTANCE TOTAL 935.00 </div>
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PLEASE REFER TO THIS NUMBER AND TO THE DOCUMENT CONTROL NUMBER ON ALL CORRESPONDENCE

1 OF 1

DPA 194-M-2 (R-4-91)

GENERAL APPENDIX 10

PROVIDER FORMS REQUEST INSTRUCTIONS

=The Department of Public Aid provides required billing forms (with the exception of the UB-92 claim form), prior approval request forms, adjustment forms and various types of pre-addressed mailing envelopes to be used by the providers to submit claims and adjustments to the Department. Single sheet billing forms are intended for use only in laser printers. Multi-page continuous feed forms are intended for use in either typewriters or impact printers.

These materials may only be obtained by submitting Form DPA 1517/1517A, Provider Forms Request, to the Department as described below. The Department will not mail forms (except Form DPA 1517/1517A) in response to telephone requests. Local Department of Human Services offices do not maintain a supply. The provider should submit the Provider Forms Request at least three weeks in advance.

Supplies of either Form DPA 1517 or 1517A may be obtained by calling the appropriate numbers below:

For the counties of Cook, DuPage, Kane, Kankakee, Lake, Will and Winnebago, Form DPA 1517A may be obtained by calling (773) 650-7311.

For all other Illinois counties and all out-of-state providers, Form DPA 1517 may be obtained by calling (217) 786-6968.

PREPARATION AND MAILING INSTRUCTIONS FORM DPA 1517/1517A, PROVIDER FORMS REQUEST

Facsimiles of Form DPA 1517 and 1517A are included in this Appendix. Instructions for their completion follow in the order in which the entry fields appear on the form. The forms should be either typewritten or legibly hand printed.

Provider Name, Provider Number, and Provider Type - Enter the provider name, provider number and provider type exactly as they appear on the Provider Information Sheet.

IDPA Form Number and Quantity - Enter the IDPA form number(s) being requested. Generally, the form number is shown in the lower left corner of the form. In most cases, the form number format will be "DPA" followed by a number or number/alphabetical combination.

Enter the quantity of each form requested. The quantity should be in lots of 100, i.e., 100, 200, 500, etc. Please request a sufficient quantity to last three (3) months. If applicable, indicate whether the forms are to be either Continuous Feed or Snap Out.

IDPA Envelope Number and Quantity - Enter the IDPA envelope number being requested. The number of the envelope is shown in the lower left corner on the face of the envelope. Enter the quantity of the envelope requested. Please request a sufficient quantity to last three (3) months.

Refer to Chapter 200 of the applicable provider Handbook for the form and envelope numbers appropriate for each provider type.

Mailing Label Area (bottom of the form)

Enter the name and address to which forms and envelopes are to be sent. Inclusion of the zip code is essential. Forms and mailing envelopes will be sent only to enrolled providers. The Department of Public Aid will not provide forms or envelopes to a billing service, unless the order includes the name and provider number of a currently enrolled medical provider on whose behalf the billing service is requesting forms.

SUBMITTAL INSTRUCTIONS

Submit the original Provider Forms Request as follows:

For the counties of Cook, DuPage, Kane, Kankakee, Lake, Will and Winnebago send a Form DPA 1517A to:

= Illinois Department of Human Services
Quad County Stores
5150 West Roosevelt Road
Chicago, Illinois 60644-1437
Telephone: (773) 854-5164

For all other Illinois counties and all out-of-state providers, send a Form DPA 1517 to:

= Illinois Department of Human Services
Downstate Stores
5000 Industrial Drive
Springfield, Illinois 62703-5387
Telephone: (217) 786-6968

Questions regarding the correct completion of the Form DPA 1517 or 1517A should be directed to the appropriate phone numbers as shown above.

GENERAL APPENDIX 13

COPAYMENT PROCEDURE CODES

Code	Description
90015	Podiatrist - Office visit, new
90060	Podiatrist - Office visit, est.
98940	Chiropractor visit
98941	Chiropractor visit
98942	Chiropractor visit
98943	Chiropractor visit
99201	Physician - Office visit, new
99202	Physician - Office visit, new
99203	Physician - Office visit, new
99204	Physician - Office visit, new
99205	Physician - Office visit, new
99211	Physician - Office visit, est.
99212	Physician - Office visit, est.
99213	Physician - Office visit, est.
99214	Physician - Office visit, est.
99215	Physician - Office visit, est.
99241	Physician - Office Consult, est.
99242	Physician - Office Consult, est.
99243	Physician - Office Consult, est.
99244	Physician - Office Consult, est.
99245	Physician - Office Consult, est.
X1010	Optometrist visit

